HEAD START & EARLY HEAD START ENROLLMENT APPLICATION

THE CHILD'S INFORMATION

☐FIRST 5 ☐EHS-CCP ☐EHS ☐HS ☐LIFT

Child's Legal Name First	Middle Initial	Last

Child's Place of Birth (City, State)	Child's DOB (mm/dd/yyyy)	Sex

Child's Ethnicity	Child's Race	Child's Primary Language	Child's Secondary Language
Latino ☐ Yes ☐ No	☐Pacific Islander ☐Black ☐ White ☐Biracial/ Multi ☐Hispanic ☐ Nat. Amer. ☐Asian ☐Other_____	☐English ☐Spanish ☐Vietnamese ☐Other _____	☐English ☐Spanish ☐Vietnamese ☐Other _____

THE CHILD'S HOUSEHOLD FAMILY INFORMATION

1 Primary adult name	Latino? Yes ☐ No ☐ Race	Primary Language if different from child	Secondary Language if Different from child

2 Secondary adult (if any)	Latino? Yes ☐ No ☐ Race	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated	Parental Status: ☐One parent ☐Two parents ☐Foster parent

Residential Address			Mailing Address (if different from Residential Address)		
City	State CA	Zip Code	City	State	Zip Code

Primary Phone Number (including area code)	Other Phone (including area code)

Total in Family	Total # of Children		

Is your child related to a Preschool Services Department Employee?
☐ **No** ☐ **Yes** **Employee Relationship to child:**_____

Email Address:

Current Housing: ☐Rent ☐Own ☐ Homeless
☐Other_____
If not homeless, date you moved in_____
Previous Housing: ☐Rent ☐Own ☐Homeless
☐Other_____

ELIGIBILITY INFORMATION

Family Receives :	Check one if applicable:	Does Family Have Medical Insurance?
SSI YES ☐ NO ☐ TANF/CalWORKS YES ☐ NO ☐	☐Medi-cal ☐IEHP ☐Healthy Families ☐Emergency ☐ Other	☐Yes ☐No
Does family receive WIC? ☐Yes ☐No	**Does Family Receive CalFRESH (EBT)?** ☐Yes ☐No	**Does Child Have Dental Insurance?** ☐Yes ☐No

How did you hear about us? ☐ Community Event ☐ Flyer/Poster ☐ School District ☐Community Partner Referral ☐ Former Parent ☐ Other Head Start ☐State Preschool ☐Facebook ☐Local Community Agency Referral ☐ Public Advertisement ☐ Family Friend ☐ Mailings ☐ Public Service Announcements (TV/Radio) ☐ Other _____

PARENT AND/OR GUARDIAN	INCOME SOURCE
1	☐Employment ☐Disability ☐Unemployment Benefits ☐Other_____
2	☐Employment ☐Disability ☐Unemployment Benefits ☐Other_____

PRENATAL INFORMATION

☐ **N/A** ☐ **Pregnant before Enrollment** ☐ **First Pregnancy** **Expected delivery date: _____**

ADULT HOUSEHOLD FAMILY MEMBER INFORMATION

(Please only include adults in the household supported by the income of the parent.)

(Enter Primary Adult First) First & Last Name	Date of Birth	How Related to Applicant	Sex	Education Level	Employment Status	Attending school/training
1						
2						
3						
4						

First & Last Name of Children in Home	How Related to Applicant	Date of Birth	Sex	Notes
1	**Applied Child**			
2				
3				
4				
5				
6				

TRANSPORTATION INFORMATION

What type of transportation do you use? Check one. ☐**Car** ☐**Bus** ☐**Walk** ☐**Other**

If available, is a Head Start school bus needed? ☐**Yes** ☐**No** If needed, why?

Children with special needs may receive priority for Head Start enrollment. Your disclosure of this information is strictly Voluntary.

1. Does your child have a disability? _____ (If no, please go to question #6)
2. Type of special need or disability _____
3. Has the disability been professionally diagnosed? (If yes, at what age _____? By whom? _____
4. Does the child have an IFSP/IEP? _____
5. Is the child receiving special services for the disability? _____
6. In your opinion, does your child have a special need that has not yet been diagnosed?
   If yes, please explain: _____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Children and pregnant mothers that are determined to be eligible for the Early Head Start program are eligible until the child turns 3 years old (4 years old if the child is in family child care).

Applicant Signature : **Date:**

TO BE COMPLETED BY STAFF

Initial Enrollment Program Year:	**Center Name:**	**Family ID:** **Child ID:**	**First Day Child Attended Class (Entry):**
Acceptance Status (circle): **Accept Denied**	**Program Type:** ☐**EHS** ☐ **EHS-CCP** ☐ **HS** ☐**First 5** ☐**LIFT**	**Program Option** ☐**Home Base** ☐**Full Day** ☐**Part Day**	

Income Eligibility (select only one):
☐**Income** (below federal poverty guidelines) ☐**Over-income**
Documents Verified (select as many as apply):
☐ Check Stub ☐ W2 ☐ Written Statement from Employer ☐**TANF/CalWORKs** ☐**SSI** ☐ Unemployment
☐ Document of no income ☐ Other _____
Total Annual Income: $_____

Categorical Eligibility (select one):
☐**Homeless** ☐**Foster Care** **CD 9600 date: _____**
Documents Verified (select one):
☐ Foster Care Reimbursement
☐ Statement from homeless services provider
☐ Other _____
First date of subsidized service:_____

Birth Verified By **Birth Certificate** ☐ **Passport** ☐ **Medi-cal Card** ☐ **Other** ☐_____	**Age by September 1st:**	**Months at time of Enrollment (EHS & EHS-CCP only):**

Verifying Staff Member Signature: **Print Name** **Date:**

Verifying Staff Member Signature (2nd year) : **Print Name** **Date:**

Parent confirms eligibility for 2nd year of Head Start based on Head Start Regulations (1305.7(c))

☐ **In-person Interview** ☐ **Phone Interview:** _____

_____

_____

Provide reason for phone interview in lieu of in-person interview